



Health Reimbursement Account

Plan Document

**HEALTH REIMBURSEMENT ACCOUNT
FOR FACULTY AND STAFF OF
VANDERBILT UNIVERSITY**

Restated effective January 1, 2017

**ARTICLE 1
INTRODUCTION**

1.1 **Restatement of Plan.** Vanderbilt University hereby restates the Vanderbilt University Health Reimbursement Arrangement (the "Plan") effective January 1, 2017. This Plan is designed to permit an Eligible Employee to obtain reimbursement of Covered Expenses on a pre-tax basis from the HRA Account. Participation in the Plan is limited to Eligible Employees employed on or before December 31, 2004. Effective December 31, 2016, the Employer ceased making contributions to the Plan; however, Participants with balances in their HRA Accounts as of December 31, 2016 shall continue to receive reimbursement of Covered Expenses as provided herein.

1.2 **Legal Status.** This Plan is intended to qualify as an employer-provided medical reimbursement plan under Code §§ 105 and 106 and regulations issued thereunder, and as a health reimbursement arrangement as defined under IRS Notice 2002-45, and shall be interpreted to accomplish that objective. The Covered Expenses reimbursed under the Plan are intended to be eligible for exclusion from participating Employees' gross income under Code § 105(b).

**ARTICLE 2
DEFINITIONS**

Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in this ARTICLE 2.

2.1 **"Administrator"** means Vanderbilt University. The Administrator may delegate its duties to a third party administrator who has the full authority to act on behalf of the Administrator, except with respect to appeals, for which the Employer has the full authority to act, as described in Article 8.

2.2 **"Benefits"** means the reimbursement benefits for Covered Expenses described under ARTICLE 6.

2.3 **"COBRA"** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

2.4 **"Code"** means the Internal Revenue Code of 1986, as amended.

2.5 **"Coverage Period"** means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date participation commences, as described in Section 3.1; and (b) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date participation terminates, as described in Section 3.2. A different Coverage Period may be established by the Employer.

2.6 **"Covered Expenses"** has the meaning defined in Section 6.1(b).

2.7 **"Dependent"** means a Participant's spouse or dependent as defined in Code § 152 (determined without regard to Code § 152(b)(1), (b)(2) or (d)(1)(B)) that is enrolled in the Health Insurance Plan. A Participant's spouse or dependent that is not enrolled in the Health Insurance Plan shall not be an eligible Dependent under this Plan. "Dependent" also includes a Participant's child within the meaning of Code § 152(f)(1) who has not attained age 27 as of the end of the Plan Year. Notwithstanding the foregoing, the HRA Account will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent".

2.8 **“Eligible Employee”** means an Employee eligible to participate in this Plan, as provided in Section 3.1.

2.9 **“Employee”** means an individual who the Employer classifies as a common-law employee and who is on the Employer’s W-2 payroll, but does not include the following:

a. any leased employee (including but not limited to those individuals defined as leased employees in Code § 414(n)) or an individual classified by the Employer as a contract worker or independent contractor for the period during which such individual is so classified, whether or not any such individual is on the Employer’s W-2 payroll or is determined by the Internal Revenue Service or others to be a common-law employee of the Employer;

b. any individual who performs services for the Employer but who is paid by a third-party temporary or other external employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the Internal Revenue Service or others to be a common-law employee of the Employer;

c. any non-resident aliens who receive no U.S.-source income during the Plan Year; and

d. any self-employed individual (including a partner), or a person who owns (or is deemed to own) more than 2 percent of the outstanding stock of an S corporation.

The term “Employee” does include “former Employees” for the limited purpose of allowing continued eligibility for benefits in accordance with Section 3.2.

2.10 **“Employer”** means Vanderbilt University and any Related Employer that adopts this Plan with the approval of the Employer. Related Employers, if any, that have adopted this Plan are listed in Appendix A to this Plan. However, for purposes of ARTICLE 9 and Section 10.6, “Employer” means only Vanderbilt University.

2.11 **“ERISA”** means the Employee Retirement Income Security Act of 1974, as amended.

2.12 **“FMLA”** means the Family and Medical Leave Act of 1993, as amended.

2.13 **“Health FSA”** means a health flexible spending arrangement as defined in Prop. Treas. Reg. § 1.125-5.

2.14 **“Health Insurance Plan”** means the group medical policy the Employer maintains for its Employees and their Dependents who may be eligible under the terms of such plan, providing major medical type benefits through a group insurance policy and which meets the requirements for a group health plan that provides “minimum value” under the Patient Protection and Affordable Care Act.

2.15 **“Highly Compensated Individual”** means an individual defined under Code § 105(h), as amended, as a “highly compensated individual” or “highly compensated employee.”

2.16 **“HIPAA”** means the Health Insurance Portability and Accountability Act of 1996, as amended.

2.17 **“HRA”** means a health reimbursement arrangement as defined in IRS Notice 2002-45.

2.18 **“HRA Account”** means the HRA Account described in Section 6.3.

2.19 **“Maximum Benefit Amount”** means the maximum amount to be allocated by the Employer to each Participant’s HRA Account as determined by the Employer. The current maximum benefit amount is set forth in Section 6.2.

2.20 **“Participant”** means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of ARTICLE 3.

2.21 **“Plan”** means the Health Reimbursement Account for Faculty and Staff of Vanderbilt University as set forth herein and as amended from time to time.

2.22 **“Plan Year”** means the 12-month period commencing January 1 and ending on December 31, except in the case of a short plan year representing the initial Plan Year or where the Plan Year is being changed, in which case the Plan Year shall be the entire short plan year.

2.23 **“QMCSO”** means a qualified medical child support order, as defined in ERISA § 609(a).

2.24 **“Related Employer”** means any employer affiliated with Vanderbilt University that, under Code § 414(b), (c), or (m), is treated as a single employer with for purposes of Code § 105.

2.25 **“USERRA”** means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

ARTICLE 3 ELIGIBILITY AND PARTICIPATION

3.1 **Eligibility to Participate.** An Employee will be an Eligible Employee if he or she meets the following criteria:

- a. is an Employee employed by the Employer whose employment began on or before December 31, 2004;
- b. regularly works thirty (30) hours or more per week;
- c. has completed five (5) years of continuous employment (applicable only to employees whose employment began on or after April 1, 1996); and
- d. is a Participant in the Health Insurance Plan.

3.2 **Termination of Participation.** A Participant will cease to be a Participant in this Plan upon the earlier of (i) the termination of this Plan or (ii) the last day of the month in which the Employee ceases (because of retirement, termination of employment, layoff, reduction in hours, or any other reason) to be an Eligible Employee, provided that eligibility may continue beyond such date for purposes of COBRA coverage, as may be permitted by the Administrator on a uniform and consistent basis under Section 6.6. Reimbursements from the HRA Account after termination of participation will be made pursuant to Section 6.6 (relating to a run-out period for submitting claims incurred prior to termination and relating to COBRA).

3.3 **Waiver of Future Reimbursements.** Eligible Employees may permanently opt out of and waive future reimbursements from the Plan during the annual open enrollment period for the Health Insurance Plan and upon termination of employment.

3.4 **FMLA and USERRA Leaves of Absence.** Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA or USERRA, then to the extent required by the FMLA or USERRA, as applicable, the Employer will continue to maintain the Participant’s Benefits on the same terms and conditions as if the Participant were still an active Employee.

3.5 **Non-FMLA and Non-USERRA Leaves of Absence.** If a Participant goes on a leave of absence that is not subject to the FMLA or USERRA, the Participant will be treated as having continued participation in the Plan. Claims incurred during such leave of absence that are Covered Expenses as defined herein shall be eligible for reimbursement under the Plan.

**ARTICLE 4
METHOD AND TIMING OF ENROLLMENT**

4.1 **Enrollment When First Eligible.** An Eligible Employee will commence participation in the Plan on their enrollment in the Health Insurance Plan.

4.2 **Month-to-Month Participation.** Once enrolled, the Employee's participation will continue from month-to-month until the Employee's participation ceases pursuant to Section 3.2.

**ARTICLE 5
BENEFITS OFFERED AND METHOD OF FUNDING**

5.1 **Benefits Offered.** When an Eligible Employee became a Participant in accordance with ARTICLE 3 and ARTICLE 4, a HRA Account was established for such Participant to pay Benefits in the form of reimbursements for Covered Expenses. In no event shall Benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Covered Expenses.

5.2 **Employer Only Contributions.** The Employer funds the full amount of the HRA Accounts. There are no Participant contributions for Benefits under the Plan. Under no circumstances will the Benefits be funded with salary reduction contributions, employer contributions (e.g., flex credits) or otherwise under a cafeteria plan.

5.3 **Funding This Plan.** All of the amounts payable under this Plan shall be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer or the Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid.

**ARTICLE 6
HEALTH REIMBURSEMENT BENEFITS**

6.1 **Benefits.** Under the HRA Account, a Participant may receive reimbursement of Covered Expenses incurred during a Coverage Period for himself or herself or his or her Dependents, subject to the maximum benefit limit set forth in Section 6.2(a).

a. **Incurred.** A Covered Expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care. Covered Expenses incurred before a Participant first becomes covered by the Plan are not eligible. However, a Covered Expense incurred during one Coverage Period may be paid during a later Coverage Period, provided that the Participant was a Participant in the Plan during both Periods of Coverage.

b. **Covered Expenses Generally.** Subject to the maximum benefit limit set forth in Section 6.2(a), "Covered Expenses" means co-payments, co-insurance, and deductibles under the Health Insurance Plan, as well as medical care as defined in Code § 213(d).

c. **Covered Expenses Exclusions.** "Covered Expenses" shall not include (1) health insurance premiums for individual policies or for any other group health plan (including a plan sponsored by the Employer), (2) any expense incurred for medical care, services or products that are excluded from coverage under the Health Insurance Plan or (3) any expense that does not constitute "medical care" as defined under Code § 213(d). "Covered Expenses" shall also not include any expense incurred by a Participant who is covered under a high deductible health plan offered by the Employer and has a Health Savings Account unless such expense is for or related to "permitted insurance" or "permitted coverage" as those terms are defined in Code § 223(c)(1)(B).

Notwithstanding anything in the Plan to the contrary, a Participant may not be reimbursed for the cost of any medicine or drug that is not "prescribed" within the meaning of Code § 106(f) or is not insulin. In addition, only

medicine or drugs considered to be prescription drugs under Code § 106(f), including “over-the-counter” drugs obtained under prescription, shall be able to be purchased by debit and/or credit cards issued to be used in conjunction with the Plan. Any purchase must comply with the conditions set forth in Internal Revenue Service Notice 2010-59 (for “90 percent pharmacy” purchases) and Notice 2011-5 (for all other purchases), and any subsequent IRS guidance.

d. **Cannot Be Reimbursed or Reimbursable from Another Source.** Covered Expenses can be reimbursed only to the extent that the Participant or other person incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through other insurance or any other accident or health plan. If only a portion of a Covered Expense has been reimbursed elsewhere, the HRA Account can reimburse the remaining portion of such Expense if it otherwise meets the requirements of this ARTICLE 6.

e. **Effect of Health FSA.** If the Employer offers a Health FSA and if a Participant of this Plan has made salary reduction contributions to such Health FSA during a Plan Year, reimbursement shall first be made from the Health FSA and only when the Participant has reached the maximum reimbursement allowed under the Health FSA shall reimbursement be made under this Plan.

6.2 **Benefit Amount.**

a. **Maximum Contribution Amount.** For Plan Years beginning before January 1, 2017, the maximum contribution amount credited to a Participant for a Plan Year is \$300, evidenced by deposits made by the Employer of \$25.00 per Plan calendar month into each Participant’s HRA Account beginning with the first month in which they became eligible. Effective December 31, 2016 all contributions by the Employer ceased.

b. **Changes.** The Employer may increase or decrease the maximum reimbursement amount.

c. **Nondiscrimination.** Reimbursements to Highly Compensated Individuals may be limited or treated as taxable compensation to comply with Code § 105(h), as may be determined by the Employer in its sole discretion.

6.3 **Establishment of Account.** The Administrator will establish and maintain an HRA Account with respect to each Participant but will not create a separate fund or otherwise segregate assets for this purpose. The HRA Account so established will merely be a recordkeeping account with the purpose of keeping track of reimbursements made to a Participant by the Plan.

a. **Crediting of Accounts.** For Plan Years beginning before January 1, 2017, a Participant’s HRA Account was credited \$25.00 each month. Effective December 31, 2016 all contributions by the Employer ceased. In no event will the total amount credited to a Participant’s HRA Account for a Plan Year exceed the Maximum Contribution Amount set forth in Section 6.2(a).

b. **Debiting of Accounts.** A Participant’s HRA Account will be debited during each Coverage Period for any reimbursement of Covered Expenses incurred during the Coverage Period.

c. **Available Amount.** The amount available for reimbursement of Covered Expenses is the total amount of deposits made as set forth in Section 6.3(a), reduced by prior reimbursements paid to or on behalf of a Participant during a Plan Year, and including amounts carried over as set forth in Section 6.4.

6.4 **Carryover of Account Balances/Forfeitures.** If any balance remains in a Participant’s Health Reimbursement Account after all reimbursements have been made for a Coverage Period, such balance shall be carried over to reimburse the Participant for Medical Care Expenses incurred during a subsequent Coverage Period. Upon termination of employment or other loss of eligibility, a Participant’s coverage ceases, and expenses incurred after such time will not be reimbursed unless continuation coverage is elected as provided in Section 6.6. In addition, any reimbursement payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Coverage Period in which the medical expense was incurred shall be forfeited.

6.5 Reimbursement Procedure.

a. Effective January 1, 2017, reimbursement of Covered Expenses to Participants shall be made pursuant to the following timeline depending on the balance existing in a Participant's HRA Account as of such date:

Balance (as of Jan. 1, 2017)	Covered Expenses must be incurred by:	Claims must be filed by:
\$500 or less	March 15, 2018	April 15, 2018
\$501 - \$1,000	March 15, 2019	April 15, 2019
\$1,001 - \$2,500	March 15, 2020	April 15, 2020
\$2,501 - \$5,000	March 15, 2021	April 15, 2021
More than \$5,000	March 15, 2022	April 15, 2022

b. **Timing.** Within 30 days after receipt by the Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Covered Expenses subject to Section 6.3(c) (if the Administrator approves the claim), or the Administrator will notify the Participant that his or her claim has been denied (see Section ARTICLE 8 regarding procedures for claim denials and appeals procedures). This time period may be extended for an additional 15 days for matters beyond the control of the Administrator, including in cases where a reimbursement claim is incomplete. The Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete an incomplete reimbursement claim.

c. **Claims Substantiation.** A Participant who seeks Benefits under this Plan may apply for reimbursement by submitting an application in writing to the Administrator, in such form as the Administrator may prescribe, no later than April 15th following the close of the Plan Year in which the Covered Expense was incurred, setting forth:

- i. the person or persons on whose behalf Covered Expenses have been incurred;
- ii. the nature and date of the Expenses so incurred;
- iii. the amount of the requested reimbursement; and
- iv. a statement that such Expenses have not otherwise been reimbursed and are not reimbursable through any other source.

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing that the Covered Expenses have been incurred and the amounts of such Expenses, together with any additional documentation that the Administrator may request.

d. **Debit Card.** Each Participant will be provided with a Health Care Debit Card that may be used to pay for certain Covered Expenses directly from his or her Health Reimbursement Account subject to applicable Internal Revenue Code regulations and guidance. Use of the Health Care Debit Card is voluntary. Participants who decide not to use the Health Care Debit Card may be reimbursed for Covered Expenses by submitting a claim under Section 6.5(b) above.

e. **Claims Denied.** For reimbursement claims that are denied, see the appeals procedure in ARTICLE 78.

6.6 Reimbursements After Termination; COBRA. When a Participant ceases to be a Participant under Section 3.2, the Participant will only be eligible to receive reimbursements for Covered Expenses incurred after his or her participation terminates as provided in Section 6.6(a) or (b) below.

a. To the extent required by COBRA, the Participant and his or her Dependents (Qualified Beneficiaries), whose coverage terminates under the HRA Account because of a COBRA qualifying event and who elects COBRA continuation coverage with respect to his or her coverage under the Health Insurance Plan, shall be given the opportunity to continue (on a self-pay basis) the same coverage that he or she had under the HRA Account the day before the qualifying event for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA) as provided in Article 7.

b. As an alternative to the COBRA continuation coverage described in Section 6.6(a) above, a Participant may elect to continue to receive reimbursements for Covered Expenses incurred following the date his or her participation in the Plan terminates until the earlier of (1) the end of the run-out period applicable to the Participant under Section 6.5(a) above or (2) the expiration of six (6) months following termination of participation pursuant to Section 3.2. The continuation coverage provided under this Section 6.6(b) shall be at no cost to the Participant. Upon the earlier to occur of options (1) or (2), such Participant shall have no further right to receive reimbursements of Covered Expenses and, in the case of option (2), any remaining balance in Participant's HRA Account at the end of the six (6) month period shall be forfeited. Notwithstanding the Participant's election of either (1) or (2) above, when the balance in the Participant's HRA Account reaches zero, the Participant's right to continue to receive reimbursements under this Section 6.6(b) shall end.

Notwithstanding the above, a Participant (or the Participant's estate) may claim reimbursement for any Covered Expenses incurred during the Coverage Period prior to termination of participation, provided that the Participant (or the Participant's estate) files a claim by April 15th of the year following the year of the termination of Participant's participation.

6.7 Named Fiduciary; Compliance with ERISA, COBRA, HIPAA, etc. Vanderbilt University is the named fiduciary for the Plan for purposes of ERISA § 402(a). Benefits shall be provided in compliance with ERISA, COBRA, HIPAA, FMLA, USERRA, and other group health plan laws to the extent required by such laws.

6.8 Coordination of Benefits. Benefits under this Plan are intended to pay benefits solely for Covered Expenses not previously reimbursed or reimbursable elsewhere. To the extent that an otherwise eligible Covered Expense is payable or reimbursable from another source, that other source shall pay or reimburse prior to payment or reimbursement from this Plan.

6.9 Qualified Medical Child Support Order.

a. The Administrator will adhere to the terms of any qualified medical child support order ("QMCSO") that satisfies the requirements of this Section and ERISA § 609. For purposes of this section, a qualified medical support order is a medical child support order that creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to receive benefits payable with respect to a participant or beneficiary under a group health plan. A qualified medical child support order is any judgment, decree or order (including approval of a property settlement agreement) issued by a court of competent jurisdiction or through an administrative process established under state law which:

i. relates to the provision of child support with respect to the child of a participant under a group health plan (including this Plan) or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to such benefit under such group health plan; or

ii. enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13623 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan, if such judgment, decree, or order (I) is issued by a court of competent jurisdiction or (II) is issued through an administrative process established under state law and has the force and effect of law under applicable state law.

For purposes of this section, an "alternate recipient" will mean any child of a participant who is recognized by a medical child support order as having a right to enrollment under a group health plan with respect to such participant.

b. Participants and beneficiaries may obtain, without charge, a copy of the Plan's qualified medical child support procedures from the Administrator.

6.10 Womens' Health and Cancer Rights Act. If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for: all states of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications of the mastectomy, including lymphedemas. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. If you would like more information on WHCRA benefits, call the Plan administration at the number provided in Article 13.

6.11 Newborns' and Mothers' Health Protection. Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborns' attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

6.12 Loss of Benefit. You may lose all or part of your account if we cannot locate you when your benefit becomes payable to you. You may not alienate, anticipate, commute, pledge, encumber or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the Plan, except that you may designate a beneficiary.

ARTICLE 7 CONTINUATION OF COVERAGE

7.1 Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Dependents, as applicable, whose coverage terminates because of a COBRA qualifying event (as who is a qualified beneficiary as defined under COBRA) shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had the day before the qualifying event for the periods prescribed by COBRA. Such individuals will be notified if they are eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the remainder of the Plan Year in which the qualifying event occurs; such COBRA coverage will cease at the end of the Plan Year and cannot be continued for the next Plan Year. Such continuation coverage shall be subject to all conditions and limitations under COBRA. In order to elect COBRA continuation coverage for this Plan, a Participant must elect COBRA continuation coverage for his or her coverage under the Health Insurance Plan.

Contributions for coverage under the Plan may be paid on a pre-tax basis for current Participants receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either (a) because the Participant ceases to be eligible because of a reduction of hours or (b) because the Participant's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g. Participants who cease to be eligible because of retirement, termination of employment, or layoff), contributions for COBRA coverage for benefits under the Plan shall be paid on an after-tax basis (unless permitted otherwise by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

Federal law requires group health plans with more than 20 participants to offer COBRA continuation coverage to certain participants and beneficiaries who lose coverage due to certain qualifying events. If the Employer is subject to and the Plan is covered by such federal law, it offers optional COBRA continuation coverage to you and/or your dependents if coverage of the eligible beneficiary would otherwise end due to one of the following

events:

- a. Termination of your employment for any reason except gross misconduct. Coverage may continue for you and your eligible dependents.
- b. A reduction in hours worked by you. Coverage may continue for you and your eligible dependents.
- c. Your death. Coverage may continue for your eligible dependents.
- d. Divorce or legal separation from your spouse. Coverage may continue for that former spouse and your other eligible dependents.
- e. You become entitled to Medicare. Coverage may continue for eligible dependents who are not entitled to Medicare.
- f. Loss of eligibility of a covered dependent child. Coverage may continue for that dependent.

NOTE: To choose this COBRA continuation coverage, an individual must be a covered person under the Plan on the day before the qualifying event or be born to or adopted by you during the period of your COBRA continuation coverage.

These provisions provide for the continuation of the coverage you were receiving immediately before the qualifying event. You will not be allowed to change from this coverage once COBRA continuation coverage is elected except as provided below:

g. If you are relocating and your coverage includes a region-specific benefit package that will not service your health needs in the area to which you relocate, you will be allowed to change your COBRA continuation coverage. In such a case, you will be given, within a reasonable period after requesting a change in coverage, an opportunity to elect alternative coverage that the Employer makes available to active employees. If the Employer makes coverage available to similarly situated non-COBRA beneficiaries that can be extended in the area to which you are relocating, then that coverage is the alternative coverage that must be made available to you. The effective date of your alternative coverage will not be later than the date of your relocation, or, if later, the first day of the month following the month in which you request the alternative coverage. However, the Employer is not required to make any other coverage available to you if the only coverage that it makes available to active employees is not available in the area to which you are relocating because all such coverage is region-specific and does not service individuals in that area.

h. If the Employer makes an open enrollment period available to similarly situated active employees with respect to whom a qualifying event has not occurred, the same open enrollment period rights must be made available to each qualified beneficiary receiving COBRA continuation coverage. During any such open enrollment period you will be allowed to change your COBRA continuation coverage.

7.2 The taking of qualifying leave under the Family and Medical Leave Act ("FMLA") does not constitute a qualifying event. However, a qualifying event would occur if you are covered on the day before the first day of FMLA leave, you do not return to employment with the Employer at the end of the FMLA leave and you would, in the absence of COBRA continuation coverage, lose coverage under the Plan. In such a case, the qualifying event would occur on the last day of your FMLA leave and your period of maximum coverage would be measured from that date. If, however, coverage under the Plan is lost at a later date and the Plan provides for an extension of coverage, then the maximum coverage period is measured from the date when your coverage is lost.

7.3 You or other qualifying individual(s) have the responsibility to inform the Plan Administrator of a divorce, legal separation or a child losing dependent status under the Plan within 60

days of the qualifying event. Failure to provide this notification within 60 days will result in the loss of COBRA continuation coverage rights. You must provide such notice in writing to:

**Benefit Express
P.O. Box 189
Arlington Heights, IL 60006
(877) 837-5017**

The Employer has the responsibility of notifying the Plan Administrator of your death, termination of employment, reduction in hours, or entitlement to Medicare within 30 days of the qualifying event. The Plan will notify you and other qualifying individual(s) of COBRA continuation coverage rights within 14 days of the notice described above. You and any other qualifying individuals will then have 60 days to elect COBRA continuation coverage. Failure to elect COBRA continuation coverage within 60 days after being notified by the Plan Administrator will result in loss of COBRA continuation coverage rights.

7.4 Once you and any other qualifying individuals elect COBRA continuation coverage and make the first premium payment as provided below, your COBRA continuation coverage will be effective retroactive to the date of your qualifying event. Any expenses incurred by you or a qualifying individual during the election period will be paid pursuant to the provisions of the Plan.

7.5 The maximum period of COBRA continuation coverage for individuals who qualify

a. due to termination of employment or reduction in hours worked is:

i. 18 months from the date of the qualifying event; or

ii. If a qualifying individual is disabled (as determined under the Social Security Act) at the time of your termination or reduction in hours or becomes disabled at any time during the first 60 days of COBRA continuation coverage, such continuation coverage for the qualifying individual and any non-disabled family members who are also entitled to COBRA continuation coverage may be extended to 29 months provided the qualifying individual or family member, if applicable, notifies the Plan Administrator within the 18-month COBRA continuation coverage period and within 60 days after receiving notification of disability determination. The Plan Administrator must also be notified of final determination that the qualifying individual is no longer disabled within 30 days of the date of the final determination.

b. due to any other described qualifying event is 36 months from the date of the qualifying event.

7.6 The maximum period for COBRA continuation of coverage for a child born to, adopted or placed for adoption with the covered employee is measured from the date of the parent's qualifying event.

7.7 If an individual experiences more than one qualifying event, the maximum period of coverage will be computed from the date of the earliest qualifying event, but will be extended to the full 36 months if required by the subsequent qualifying event.

7.8 If you are entitled to Medicare and your Spouse and dependent children would otherwise lose coverage because of a qualifying event which is either your termination of employment or reduction in hours, continuation coverage for your Spouse and dependent children will end on the later of (i) 36 months from the date you become entitled to Medicare or (ii) 18 months (or 29 months if there is a disability extension) after your termination of employment or reduction in hours.

7.9 The cost of COBRA continuation coverage is determined by the Employer and paid by the qualifying individual. If the qualifying individual is not disabled, the applicable premium cannot exceed 102% of the plan's cost of providing coverage. The cost of coverage during a period of extended continuation coverage due to a disability cannot exceed 150% of the Plan's cost of coverage. Effective January 1, 2017 the cost of COBRA continuation coverage shall be \$15.00 per month.

7.10 You and other qualified individual(s) must make the first payment within 45 days of notifying the Plan of selection of COBRA continuation coverage. Future payments can be made in monthly installments within 30 days of the due date unless the Employer establishes a longer payment schedule. Rates and payment schedules are established by the Employer and may change when necessary due to Plan modifications.

7.11 The cost of COBRA continuation coverage is computed from the date coverage would normally end due to the qualifying event.

7.12 If timely payment is made in an amount that is not significantly less than that amount required to be paid (\$50.00 or 10% of the amount required to be paid, whichever is less), the Plan Administrator will notify you of the amount of the deficiency. You will have 30 days after the date the notice is provided to you to pay the deficiency. Failure to make the first payment within 45 days or any subsequent payment within 30 days of the established due date will result in the permanent cancellation of continuation coverage.

7.13 When COBRA Continuation Coverage Ends. COBRA Continuation of coverage ends on the earliest of:

- a. The date the maximum COBRA continuation period expires.
- b. The date the qualifying individual first becomes entitled to coverage under Medicare if such entitlement occurs after the date of the continuation of coverage election.
- c. The last period for which payment was made when coverage is canceled due to non-payment of the required cost.
- d. The date the Employer no longer offers a health care reimbursement plan to any of its employees.
- e. The date, after the date of the COBRA continuation of coverage election, the qualifying individual first becomes covered under any other health care reimbursement plan that does not exclude or limit coverage for a pre-existing condition the qualifying individual may have or when such limitation is satisfied due to application of prior creditable coverage as required under the Health Insurance Portability and Accountability Act (HIPAA).
- f. When COBRA coverage has been extended up to 29 months due to disability, the date a final determination is made by the Social Security Administration that the qualified individual is no longer disabled.

7.14 **In order to protect your rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator. If you have any questions concerning your rights under COBRA, contact:**

Benefit Express
P.O. Box 189
Arlington Heights, IL 60006, (877) 837-5017

ARTICLE 8 APPEALS PROCEDURE

8.1 Timing of Notification of Benefit Determination. If a claim is wholly or partially denied, the Participant shall be notified of the adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the Participant prior to the termination of the initial 30-day period. In no event shall such extension exceed a period of 30 days from the end of such initial period. The extension notice shall indicate that the special circumstances requiring an extension of time and the date by which the benefit determination is expected to be rendered.

8.2 Calculating time periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing.

8.3 Manner and Content of Notification of Benefit Determination. A Participant shall be provided with written notification of any adverse benefit determination. The notification shall set forth, in a manner calculated to be understood by the Participant, the following:

- a. the specific reason or reasons for the adverse determination;
- b. reference to the specific plan/policy provisions on which the determination is based;
- c. a description of any additional material or information necessary for the Participant to perfect the claim and an explanation of why such material or information is necessary;
- d. a description of the review procedures and the time limits applicable to such procedures, including a statement of the Participant's right to bring a civil action under § 502(a) of ERISA (where applicable), following an adverse benefit determination on review; and
- e. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Participant upon request.

8.4 Appeals of Adverse Benefit Determination. Appeals of adverse benefit determinations may be submitted in accordance with the following procedures:

- a. Participants (or their authorized representatives) must submit an appeal within 180 days following their receipt of a notification of an adverse benefit determination, and only one appeal is allowed;
- b. Participants shall have the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
- c. Participants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits;
- d. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
- e. No deference to the initial adverse benefit determination shall be afforded upon appeal;

f. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and

g. Any medical or vocational expert(s) whose advice was obtained in connection with a Participant's adverse benefit determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination.

8.5 Timing of Notification of Benefit Determination on Review.

a. The Participant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the Participant's timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the Participant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

b. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is timely filed, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as above due to a Participant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the Participant until the date on which the Participant responds to the request for additional information.

8.6 Manner and Content of Notification of Benefit Determination on Review. A Participant shall be provided with written notification of the benefit determination on review. In the case of an adverse benefit determination on review, the notification shall set forth, in a manner calculated to be understood by the Participant, the following:

- a. the specific reason or reasons for the adverse determination;
- b. reference to the specific plan/policy provisions on which the determination is based;
- c. a statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits;
- d. a statement of the Participant's right to bring an action under § 502(a) of ERISA (where applicable); and
- e. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Participant upon request.

8.7 External Appeal.

a. To the extent applicable to the Plan under the Patient Protection and Affordable Care Act ("ACA"), a claimant may request an external review of an adverse benefit determination from an independent review organization ("IRO") under rules specified by the Plan Administrator that are consistent with ACA requirements. Within four (4) months of receipt of the denial of the appeal by the Plan Administrator, the claimant must notify, in writing, the Plan Administrator of his or her intent to pursue an external review.

b. Within five (5) business days of receiving a request for external review, the Plan must complete a preliminary review to determine if the claimant was covered under the Plan, the claimant provided all the information and forms necessary to process the external review and the claimant has exhausted the internal appeals process. Once such preliminary review is complete, the Plan will notify the claimant in writing within one (1) business day. If the claim is not eligible for external review, such notice must include contact information for the Employee Benefits Security Administration of the Department of Labor. If the claimant's request for external review was incomplete, the notice must describe materials needed to complete the request and provide the later of 48 hours or the four month filing period to complete the filing.

c. A claimant may request an external appeal by completing a form provided by the Plan Administrator which must include the following information:

i. The claimant's name, address, daytime telephone number and email address;
and

ii. A brief description of why the claimant disagrees with the decision, along with any additional information, such as a physician's letter, bills, medical records, or other documents to support such claim.

d. If the claimant requests an external review, the IRO will be limited to the facts, evidence and issues presented during the claims procedure set forth above. The appeal process described herein must be exhausted before a claimant can pursue an external review. Facts and evidence that become known after having exhausted the appeals procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the appeal will be deemed waived.

e. The Plan must assign an accredited IRO to perform the external review. The external reviewer must notify the claimant and the Plan Administrator of its decision on the external appeal within 45 days after its receipt of the request for external review. The external reviewer's decision is binding upon the parties unless other state or federal law remedies are available. Such remedies may or may not exist. Therefore, unless another legal right exists under such claim, use of the external review process may terminate a claimant's right to bring a lawsuit on such claim.

8.8 Full and fair review. A claimant must be allowed to review the file and present evidence and testimony as part of the internal appeals process. Claimants must be provided, at no charge, with any new or additional evidence considered relied upon or generated by the Plan in connection with the claim sufficiently in advance of the final adverse benefit determination to give the claimant a reasonable opportunity to respond prior to that date. The Plan must also meet the conflict of interest requirements of DOL Regulation § 2590.715-2712(b)(2)(D).

8.9 Notice. A description of internal and external claims processes and information about how to initiate an appeal must be provided. Notices of adverse benefit determinations must include the information required under DOL Regulation § 2590.715-2719(b)(2)(ii)(E), as applicable. The final notice of internal adverse benefit determination must include a discussion of the decision. Notice must be provided in a linguistically-appropriate manner as provided under DOL Regulation § 2590-715-2719(e) and the Plan must disclose contact information for any applicable office of health insurance consumer assistance established under PHSA § 2793.

8.10 Deemed Exhaustion of Internal Claims Process. If the Plan fails to strictly adhere to the claims and appeals requirements under the ACA, as provide in DOL Regulation § 2590-715-2719(b)(2), the claimant may initiate an external review under Section 8.7 or may bring action under ERISA § 502(a).

8.11 Definitions.

a. "Adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a

Participant's or beneficiary's eligibility to participate in a plan, as well as any rescission of coverage as described in DOL Regulation § 2590.715-2712(a)(2).

b. "Relevant" means: a document, record, or other information shall be considered relevant to a Participant's claim if such document, record or other information:

i. was relied upon in making the benefit determination;

ii. was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination; or

iii. demonstrates compliance with administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated Participants.

ARTICLE 9 RECORDKEEPING AND ADMINISTRATION

9.1 **Administrator.** The administration of this Plan shall be under the supervision of the Administrator. It is the principal duty of the Administrator to see that this Plan is carried out in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination. The Employer is hereby designated as the Plan Administrator to serve until resignation or removal by the Employer's governing body and appointment of a successor by a duly adopted resolution.

9.2 **Powers of the Administrator.** The Administrator shall have such duties and powers as is necessary or appropriate to discharge the Administrator's duties. The Administrator shall have the exclusive power and discretion to construe the terms of the Plan and to determine all questions arising in connection with the administration, interpretation, and application of the Plan. All determinations of the Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Administrator shall have the following discretionary authority:

a. to construe and interpret this Plan, including all possible ambiguities, inconsistencies and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan;

b. to prescribe procedures to be followed and the forms to be used by Participants to submit claims pursuant to this Plan;

c. to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Administrator determines to be appropriate;

d. to request and receive from all Participants such information as the Administrator shall from time to time determine to be necessary for the proper administration of this Plan;

e. to furnish each Participant with such reports with respect to the administration of this Plan as the Administrator determines to be reasonable and appropriate;

f. to receive, review and keep on file such reports and information concerning the benefits covered by this Plan as the Administrator determines from time to time to be necessary and proper;

g. to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;

h. to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

i. to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

j. to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

9.3 Reliance on Participant, Tables, etc. The Administrator may rely on the information submitted by a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Administrator.

9.4 Provision for Third-Party Plan Service Providers. The Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement between the Employer and such persons, obligations under this Plan shall remain the obligation of the Employer.

9.5 Fiduciary Liability. To the extent permitted by law, the Administrator shall not incur any liability for any acts or for failure to act except for the Administrator's own willful misconduct or willful breach of this Plan.

9.6 Compensation of Plan Administrator. Unless otherwise determined by the Employer and permitted by law, any Administrator who is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of the Administrator's duties shall be paid by the Employer.

9.7 Bonding. The Administrator shall be bonded to the extent required by ERISA.

9.8 Insurance Contracts. The Employer shall have the right (a) to enter into a contract with one or more insurance companies for the purposes of providing any Benefits under the Plan; and (b) to replace any such insurance companies or contracts. Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of, and be retained by, the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such insurance.

9.9 Inability to Locate Payee. If the Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date that any such payment first became due.

9.10 Effect of Mistake. In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code § 105, the regulations issued thereunder or other applicable law, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the HRA Account or distributions to which he or she is properly entitled under the Plan.

**ARTICLE 10
GENERAL PROVISIONS**

10.1 **Expenses.** All reasonable expenses incurred in administering the Plan are currently paid by the Employer.

10.2 **No Contract of Employment.** Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time. All Employees are considered to be employed at the will of the Employer.

10.3 **Requests for Information.** The Administrator may request from a Participant information regarding the Participant and/or the Participant's Dependent(s) to ensure the Participant remains eligible for coverage under this Plan. Each Participant shall provide requested information in the form prescribed by the Administrator. Each Participant shall also provide consents, authorizations to obtain information, or other information the Administrator deems necessary or desirable to administer this Plan.

10.4 **Incapacity.** If the Administrator determines that a Participant cannot give a valid release for payment of plan benefits, the Administrator may, at its discretion, pay the individual who has assumed responsibility for the Participant's financial affairs. Any payment made by the Administrator in accordance with this provision shall fully satisfy its liability for payment.

10.5 **Misrepresentation.** If a Participant knowingly makes a statement, either verbally or in writing, that is not true and because of that statement, coverage is given to the Participant when the Participant would otherwise not be eligible for coverage, this Plan has the right to rescind coverage from the date it became effective and has the right to pursue recovery of any benefits wrongly paid to the Participant.

10.6 **Amendment and Termination.** This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Plan at any time for any reason by resolution of the Employer's Board of Directors or by any person or persons authorized by the Board of Directors to take such action, and any such amendment or termination will automatically apply to any Related Employers that are participating in this Plan.

10.7 **Governing Law.** This Plan shall be construed, administered and enforced according to the laws of the State of Tennessee to the extent not superseded by the Code, ERISA or any other federal law.

10.8 **Code and ERISA Compliance.** It is intended that this Plan meet all applicable requirements of the Code and ERISA, and of all regulations issued thereunder. This Plan shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan and the Code and/or ERISA, the provisions of the Code and/or ERISA shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

10.9 **No Guarantee of Tax Consequences.** Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state or local income tax purposes. It shall be the obligation of each Participant to determine whether any payment under this Plan is excludable from the Participant's gross income for federal, state and local income tax purposes, and to notify the Administrator if the Participant has any reason to believe that such payment is not so excludable.

10.10 **Indemnification of Employer.** If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis, and such payments do not qualify for such treatment under the Code, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

10.11 **Non-Assignability of Rights.** The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to

claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

10.12 Headings. The headings of the various Articles and Sections (but not subsections) are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

10.13 Plan Provisions Controlling. In the event that the terms or provisions of any summary or description of this Plan, or of any other instrument, are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

10.14 Severability. Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

ARTICLE 11 ERISA STATEMENT OF RIGHTS

11.1 ERISA Rights of Participants. Participants in the Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Participants shall be entitled to:

- a. receive information about the plan and benefits;
- b. examine, without charge, at the Administrator's office and at other specified locations, such as worksites, all documents governing the Plan and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- c. obtain, upon written request to the Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description, all of which the Administrator may make a reasonable charge for the copies; and
- d. receive a summary of the Plan's annual financial report.

11.2 Prudent Actions by Plan Fiduciaries. In addition to creating rights for Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Participants and beneficiaries.

11.3 Discrimination Prohibited. No one, including the Employer, or any other person, may fire a Participant or otherwise discriminate against a Participant in any way to prevent a Participant from obtaining a welfare benefit or exercising a Participant's rights under ERISA.

11.4 Enforce Participant Rights. If a Participant's claim for a welfare benefit is denied or ignored, in whole or in part, the Participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps a Participant can take to enforce the above rights.

- a. If a Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, the Participant may file suit in a Federal court. In such a case, the court may require the Administrator to provide the materials and pay the Participant up to \$110 a day until the Participant receives the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

b. If a Participant has a claim for benefits which is denied or ignored, in whole or in part, the Participant may file suit in a state or Federal court.

c. If it should happen that Plan fiduciaries misused the Plan's money, or if a Participant is discriminated against for asserting his or her rights, the Participant may seek assistance from the U.S. Department of Labor, or may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If a Participant is successful the court may order the person the Participant sued to pay these costs and fees. If a Participant loses, the court may order the Participant to pay these costs and fees, for example, if it finds the Participant's claim was frivolous.

11.5 Assistance with Questions. If a Participant has any questions about this Plan, the Participant should contact the Administrator. If the Participant has any questions about this statement or about his or her rights under ERISA, or needs assistance in obtaining documents from the Administrator, the Participant should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the Participant's local telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. The Participant may also obtain certain publications about his or her rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ARTICLE 12 HIPAA PRIVACY STATEMENT

12.1 Employer's Access to PHI. Members of the Employer's workforce have access to the individually identifiable health information of Participants for administrative functions of the Plan. When this health information is provided to the Employer, it is Protected Health Information (PHI). The Plan has also entered into a Business Associate Agreement with a third-party administrator ("TPA") under which the Plan has delegated to and the TPA has agreed to perform certain plan administration functions on behalf of the Plan. Under no circumstances will the Employer, or any employee of the Employer, have access to or receive any Protected Health Information regarding the Participants in the Plan (except as provided in Section 12.4 below and allowed under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")).

12.2 Protected Health Information. The TPA shall have access to the individually identifiable health information of Participants for administrative functions of the Plan as set forth in the Business Associate Agreement. When individually identifiable health information is provided from the Plan to the TPA, it is Protected Health Information (PHI). The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the TPA's ability to use and disclose PHI. Such use and disclosure is also governed by the terms of the Business Associate Agreement. The TPA shall have access to PHI from the Plan only as permitted under the Plan, the Business Associate Agreement or as otherwise required or permitted by HIPAA.

12.3 PHI Definition. "Protected health information" means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a Participant; and that identifies the Participant or for which there is a reasonable basis to believe the information can be used to identify the Participant. Protected health information includes information of persons living or deceased.

12.4 Provision of Protected Health Information to Employer.

a. **Permitted Disclosure of Enrollment/Disenrollment Information.** The Plan may disclose to the Employer information on whether the individual is participating in the Plan, or is enrolled in or has disenrolled from the Plan.

b. **Permitted Uses and Disclosure of Summary Health Information.** The Plan may disclose Summary Health Information to the Employer, provided that the Employer requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan. "Summary Health Information"

means information (1) that summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a Health Plan; and (2) from which the information described at 42 C.F.R. § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 C.F.R. § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

12.5 Provision of Protected Health Information to TPA.

a. **Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes.** Unless otherwise permitted by law, and subject to the conditions of disclosure described in Section 12.5b(b), the Plan may disclose PHI to the Employer or the TPA, provided that the Employer or TPA uses or discloses such PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Employer or the TPA on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions. Notwithstanding the provisions of this Plan to the contrary, in no event shall the Employer or TPA be permitted to use or disclose PHI in a manner that is inconsistent with 45 C.F.R. § 164.504(f).

b. **Conditions of Disclosure for Plan Administration Purposes.** The Employer agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Plan, it shall:

- i. not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;
- ii. ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Employer with respect to PHI;
- iii. not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
- iv. report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosure provided for of which it becomes aware;
- v. make available PHI to comply with HIPAA's right to access in accordance with 45 C.F.R. § 164.524;
- vi. make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526;
- vii. make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;
- viii. make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;
- ix. if feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- x. ensure that the adequate separation between the Plan and the Employer (i.e., the "firewall"), required in 45 C.F.R. § 504(f)(2)(iii), is satisfied.

c. **Adequate Separation between Plan and Employer.** The Employer shall allow the Associate Vice Chancellor/Chief Human Resources Officer and/or the members Vanderbilt University's Office of Benefits Administration and/or the direct billing/COBRA department access to the PHI. No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use PHI to the extent necessary to perform the plan administration functions that the Employer performs for the Plan. In the event that any of these specified employees does not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's employee discipline and termination procedures.

ARTICLE 13 GENERAL INFORMATION

13.1 Name and address of the Plan Sponsor:

Vanderbilt University
PBM #407700
2301 Vanderbilt Place
Nashville, TN 37235-7700
(615) 322-8330

13.2 Name and address of the Plan Administrator:

Vanderbilt University
PBM #407700
2301 Vanderbilt Place
Nashville, TN 37235-7700
(615) 322-8330

13.3 Name and address of the designated agent for service of legal process:

Vanderbilt University
PBM 407700
2301 Vanderbilt Place
Nashville, TN 37235-7700
(615) 322-8330

13.4 Employer Federal Identification Number: 62-0476822

13.5 Plan Number: 513

13.6 Restatement effective date: January 1, 2017

13.7 Plan Year: The Plan Year is the 12-month period beginning January 1 and ending December 31.

13.8 Type of Plan and Funding:

This Plan is a plan funded by employer contributions only. It is intended to constitute a plan as described by the Employee Retirement Income Security Act of 1974 (ERISA).

13.9 Maximum Benefit Amount:

\$300 per Plan Year

13.10 Type of Administration:

Administration of the Plan, including claims processing, is performed by a third party administrator.

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the Health Reimbursement Account for Faculty and Staff of Vanderbilt University, Vanderbilt University has caused this Plan to be executed in its name and on its behalf, on March 21, 2017.

VANDERBILT UNIVERSITY

By: 
Title: Associate Vice Chancellor and Chief
Human Resources Officer

**Appendix A - Related Employers That Have Adopted This Plan
With the Approval of Vanderbilt University**

The following related employers have adopted this plan:

None

4846-0355-9997, v. 6